Personal Health Application

Applicants must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to provide evidence of insurability.

Instructions

Employer's Responsibility:

1. Fill out the Employer Section completely. Please note an incomplete form will result in a delay in processing the applicant(s) request for insurance. Refer to your Policy and employee records. These records are your property and are not on file with Hartford's Group Medical Underwriting Department.
2. In Section #1, "Who Requires an Application," indicate with a check mark why evidence of insurability is required – for employee and/or spouse. See definitions in #3 below. Consult your Policy for all requirements, limitations, and exceptions.
3. In Section #2, "Coverage Summary," complete all coverage amounts for each Applicant. Consult your employee records to determine current coverage amounts. Please note that Hartford does not have access to employee records for amounts of coverage already in force. **Definitions of coverage requests**:
   - **Over Guaranteed Issue (GI) Limit:** Election of coverage exceeding the guaranteed issue amount (according to your contract) for which evidence of insurability is required.
   - **New Hire:** Newly hired employee electing coverage for the first time within the eligibility period, usually the first 31 days from date of hire.
   - **Opting up to Higher Level of Coverage**: Election of additional increment(s) of coverage with insurance currently in force.
   - **Late Entrant:** Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force. *(Note: Applicant is responsible for payment of any additional information required for completion of the underwriting process e.g. exams, medical records, etc).*
   - **Change in Family Status**: Election of coverage usually made within 31 days of a qualified change in family status.
4. After completing the Employer Section on page 2, forward the entire form to the employee.
5. No premiums may be deducted on additional amounts requiring evidence of insurability until a final decision regarding coverage is received from Hartford's Group Medical Underwriting Department.

Employee's Responsibility: **Upon Completion**

Send both the Employer and Employee Sections of this form to:
Group Medical Underwriting
Hartford Life Insurance Companies
PO Box 1590
Avon, CT 06001-1590

1. Make sure your Employer has already completed the Employer Section of this form in full.
2. Enter the name(s) of the Applicant(s) under "Applicants Required to Provide Evidence of Insurability." The Employer Section clarifies which Applicants need to provide evidence of insurability and should be listed on this application. A box has been marked for each person who is required to fill out the application in the section entitled "Who Requires an Application" on the "Employer" page.
3. Answer all questions completely and accurately. Even details like height and weight are very important and must be accurate. **Leaving information blank can result in delays or may result in your file being closed.**
4. An Applicant who has not enrolled during their eligibility period or annual enrollment and does not have coverage in force (shown in the Employer Section #1) will be responsible to pay for the cost of physical exams, medical records, or medical tests if they are required during the underwriting process.
5. YOU, THE EMPLOYEE, MUST SIGN THIS FORM (even if you are not applying for coverage). Use your full legal signature and enter the date signed. Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature and enter the date signed.
6. **BOTH THE EMPLOYER AND EMPLOYEE SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY HARTFORD WITHIN 30 DAYS OF THE SIGNATURE DATE**.
7. Applicant is required to notify Hartford in writing of any changes in any applicant's medical condition to the best of their knowledge, between the date the Applicant signs this form and the date the coverage is approved.

THIS PAGE TO BE COMPLETED BY **EMPLOYER** USING BLACK OR BLUE INK ONLY.

Personal Health Application

Underwriting Company (herein called **"Hartford"**): ☒ Hartford Life & Accident Insurance Company

Employer Name: **SC Budget and Control Board Employee Insurance Program**			
Entity Name:			
Mailing Address:			
City:	State:	Zip:	Policy Number: **GL-33913**
Benefits Administrator:	Telephone Number: ( )		E-Mail:
Employee Name:		Employee Social Security Number:	
Date of Hire:	Family Status Change Date:	Employee Base Annual Earnings (BAE): $	

Check box for each applicant who requires evidence of good health with a Personal Health Application (PHA), and specify the reason(s) that apply. Check all reasons that apply. Identify any applicants requiring a Personal Health Application.

1. Who requires an Application: Refer to "**Definitions of Coverage**" in #3 on the Instructions page. Select a box for each Applicant required to provide evidence of insurability.

	❑ Over Guaranteed Issue Limit	❑ Opting up to Higher Level of Coverage	❑ Late Entrant	❑ Change in Family Status
Employee (EE)	An applicant enrolling for an amount above 3x basic annual earnings if a new hire or newly enrolled employee.*	e.g. increasing in specified incremental dollar amounts as allowed by the plan.*	Employee who did not enroll during one of the following eligibility periods: 31 days from date of hire or from date of family status change, or an open enrollment.*	Employee change in coverage being made within 31 days of a qualified change in family status.*
Spouse (SP)	Spouse enrolling for more than $20,000.*	e.g. from $10,000 to $20,000 in coverage.*	Spouse did not enroll during one of the following eligibility periods: 31 days from employee date of hire or from date of family status change.*	Newly eligible spouses qualify for $10,000 or $20,000 if elected within 31 days of the change in family status.*

*Please refer to your Policy and employee records for coverage amounts, eligibility periods (for Late Entrant determination), Guaranteed Issue limits, and rules for "opting up." Please check the policy guidelines for Change in Family Status rules and exceptions.

Coverage Summary: **Complete all three columns for each Applicant**.

Life Coverages: Please be sure to include current Optional Life coverage as a dollar amount value for all applicants requesting additional life coverage. Refer to employee records for Current Coverage Amounts.

Enrollees for Life Coverage	**Current Coverage Amount In Force** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first time)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
Employee Optional Life **Name:** _____	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___
Spouse Life **Name:** _____	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___

Please note the following:

Employee Optional Life guaranteed issue is applicable only to a newly hired employee and is an amount up to and including 3x basic annual earnings.

Spouse Life guaranteed issue is applicable only to a spouse enrolling with a newly hired employee up to and including an amount of $20,000.

THE FOLLOWING PAGES TO BE COMPLETED BY **EMPLOYEE** USING BLACK OR BLUE INK ONLY.

Employee Section	**Personal Health Application**	**BEFORE MAILING**
Employee First Name: MI: Last Name:		• **Answer all the questions and DATE and SIGN this form in both areas indicated.** • Keep a copy for your records. • **Mail the completed Employer and Employee section to**: Hartford Life Group Medical Underwriting PO Box 1590 Avon, CT 06001-1590
Mailing Address:		
City: ST: ZIP:		
Social Security Number: Occupation:		
Can we call you for any additional or missing information?: YES: ☐ NO:☐	Work Phone: ( )	
E-Mail:	Home Phone: ( )	

1. Applicants Required to Provide Evidence of Insurability (This is critical information and if left blank will cause a delay in processing your insurance request). List the names of Applicants identified in Employer Section I.

First Name, MI, Last Name	ENROLLEES	HEIGHT (ft/in) Required	WEIGHT (lbs) Required	DATE OF BIRTH Required	GENDER
	Employee			__ __-__ __-__ __	M F
	Spouse			__ __-__ __-__ __	M F

2. Health Questions (**Questions 1-24 are to be answered by all Applicants listed above. If additional space is required, please attach a separate sheet. Sign and date each sheet.**) **Residents of:** Florida, Indiana, Maine, Minnesota, North Carolina, and Wisconsin, please see Variable Question Language on page 7 of the application for amended or added language to the below questions. After you have read that information, answer the questions below.

For questions 1-6, during the past 10 years, have any of the Applicants: (Residents of: Indiana, Kansas, Maryland, and Minnesota, please provide medical history during the past 5 years.**)**

	EE		SP	
1. Had any surgery or been told to have surgery?	Y	N	Y	N
2. Been in a hospital or other institution for diagnosis or treatment?	Y	N	Y	N
3. Had any injuries from a car accident or filed a Workers' Compensation Claim?	Y	N	Y	N
4. Been declined for any life or disability insurance coverage?	Y	N	Y	N
5. Consulted or been examined by any healthcare provider for anything other than normal physical exams with normal findings or acute illness such as cold, flu or sore throat?	Y	N	Y	N
6. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above?	Y	N	Y	N

*****For each "YES" answer, identify the question number, applicant name and provide details requested*****

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

EMPLOYEE FIRST NAME:_____________________________ MI: _________ LAST NAME:________________________________

For questions 7-24, during the past 10 years, have any of the Applicants at any time been treated or told they have a problem with any of the following: (Residents of: Indiana and Maryland, please provide medical history during the past 5 years.)

	EE		SP	
7. Heart condition, chest pain, high blood pressure, elevated cholesterol, heart murmur, abnormal pulse, stroke, or blood, circulatory or vascular system?	Y	N	Y	N
8. Cancer, tumors, leukemia, moles, melanoma or basal cell carcinoma?	Y	N	Y	N
9. Diabetes, thyroid, liver, hepatitis, glands or spleen?	Y	N	Y	N
10. Asthma, bronchitis, pneumonia, respiratory problems or sleep apnea?	Y	N	Y	N
11. Ulcers, stomach, colitis rectum, intestines, gallbladder, or upper or lower digestive system?	Y	N	Y	N
12. Arthritis or rheumatism?	Y	N	Y	N
13. Kidneys, bladder or urinary tract?	Y	N	Y	N
14. Genital or reproductive organ problems?	Y	N	Y	N

*****For each "YES" answer, identify the question number, Applicant name and provide details requested*****

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		
Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		
Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		
Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		
Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		
Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Answer questions for each Applicant. Provide details for all questions 1-24 answered "Yes".

EMPLOYEE FIRST NAME:______________________________ MI: __________ LAST NAME:_________________________________

	EE		SP	
15. Drug or alcohol abuse, or used alcohol or nicotine on a regular basis? Indicate amount used daily: ______	Y	N	Y	N
16. Eyes, ears, nose or throat?	Y	N	Y	N
17. Psychiatric, mental or nervous disorders, including depression and anxiety?	Y	N	Y	N
18. Back, neck, spine, bones or joints?	Y	N	Y	N
19. Immune system, anemia or other blood conditions?	Y	N	Y	N
20. Brain or nervous system problems, or epilepsy?	Y	N	Y	N
21. AIDS, AIDS-related complex, immune deficiency disorder or do you have enlarged lymph nodes or unexplained weight loss?	Y	N	Y	N
22. Are you **currently** pregnant? If yes, what was your pre-pregnancy weight? ____lbs.	Y	N	Y	N
23. Are you **currently** taking medication for any condition or disease?	Y	N	Y	N
24. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above?	Y	N	Y	N

*****For each "YES" answer, identify the question number, Applicant name and provide details requested*****

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		
Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		
Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of medical condition:	
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and **complete address:**		

Employee Primary Care Physician Name & Address:

____

____

Spouse Primary Care Physician Name & Address:

____

____

Notice: *Applicant is required to notify Hartford in writing of any changes in any applicant's medical condition to the best of their knowledge, between the date the Applicant signs this form and the date the coverage is approved.*

I hereby certify that the above statement and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statement and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. This information may be used by Hartford (for fully insured coverages) or my employer/administrator (for self-funded coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage.

____________________	____/____/____	____________________	____/____/____
EMPLOYEE'S SIGNATURE or Legal Representative/ Relationship to Employee (**required**)	DATE SIGNED	SPOUSE'S SIGNATURE or Legal Representative/ Relationship to Spouse (**required only if applying for coverage**)	DATE SIGNED

Each Applicant must sign and date above.

EMPLOYEE FIRST NAME:_____ MI: _____ LAST NAME:_____

APPLICANT AUTHORIZATION: THIS SECTION IS VERY IMPORTANT. YOUR REQUEST CANNOT BE PROCESSED WITHOUT IT.

Authorization to Disclose Protected Health Information
To Be Used To Determine Eligibility for Group Life and/or Disability Income Coverage
(Group Life and Disability Income are not subject to the requirements of HIPAA)

I have applied for insurance under a Group Life and/or Disability Policy issued by Hartford. To assess whether I am eligible for this insurance, these companies may require that I authorize disclosure of a copy of my health information. This authorization is intended to comply with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), effective April 14, 2003.

I **authorize** any: health plan, physician, medical or health practitioner, counselor, therapist, hospital, clinic, other medical or medically-related facility, or other health care provider who has provided treatment, payment, or services to me or on my behalf within the last 10 years (**Residents of Indiana** authorize within the last 5 years); insurance company; or reinsurance company, with which I have had coverage, and the Medical Information Bureau, Inc. (MIB), (collectively, "Releasers"); to disclose to Hartford, Health Information about me. Hartford may disclose the Health Information: to their agents; to their employees; and to their representatives (collectively "Hartford"); my entire Health Information. Health Information means the entire medical file. This includes, but is not limited to: x-rays; photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes, that relate to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries, or any other health conditions, 2) Confinements in hospitals, medical facilities, or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, or mental health information protected by Federal Law, 5)* Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness. But, it excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose health information to Hartford. Hartford will use this information to underwrite my request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with Hartford.

***Residents of West Virginia**, 5) reads as follows: Counseling or therapy, except that no adverse underwriting decision shall be made because I have demonstrated AIDS-related concerns or have sought AIDS-related counseling (this does not apply to my seeking treatment and/or diagnosis for Acquired Immune Deficiency Syndrome).

By signing this Authorization, I acknowledge and agree:

- That any agreements I have made to restrict disclosure of my health information do not apply to this Authorization;
- That I am authorizing the Releasers to release and disclose my entire medical file, as described above, without restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That health information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the Releasers' knowledge. Note that Hartford only will use this information to underwrite your request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to coverage you have applied for with Hartford.
- That if 1) I refuse to sign this Authorization to release my entire medical file; or 2) if this Authorization is altered by me in any way, Hartford may not be able to process my application for coverage.
- That, if 1) Hartford denies my request for coverage; and 2) this denial is based, in whole or in part, on health information obtained in connection with this Authorization; Hartford will not release this information to me unless otherwise authorized by the Releasers, including my physician or other medical professionals that disclosed such information to Hartford unless required by law.
- That, if necessary, Hartford will send this Authorization to Releasers authorized to release health information about me.
- That Hartford will also provide me with written notice of Releasers to which Hartford sends my Authorization.
- That I have a right, at any time, to revoke this Authorization. To do so, I must send a written request directly to such Releasers. My revocation will not be effective: to the extent that action has been taken in reliance upon this authorization; or, Hartford otherwise has the right: to contest the policy; or a claim under the policy.
  Residents of Virginia, review this additional text: Authorization signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits remain valid no longer than 30 months from the date the authorization is signed. Authorizations signed for the purpose of collecting information in connection with a claim for accident and sickness benefits under an insurance policy remain valid for the entire term of the coverage of the policy. Authorizations signed for the purpose of collecting information in connection with a claim for any other benefits under an insurance policy remain valid for the duration of the claim.
- That this Authorization will expire 24 months from the effective date of my coverage or if no coverage has been issued, 24 months from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original.
- That I am entitled to a signed copy of this Authorization.

_____	___/___/___	_____	___/___/___
EMPLOYEE'S SIGNATURE or Legal Representative/ Relationship to Employee (**required**)	DATE SIGNED	SPOUSE'S SIGNATURE or Legal Representative/ Relationship to Spouse (**required only if applying for coverage**)	DATE SIGNED

The above HIPPA Authorization must be signed and dated by each Applicant.

DO NOT RETURN THIS PAGE. RETAIN FOR YOUR RECORDS.

Variable question language

Florida residents:

Question 21: Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

Indiana residents:

Question 24: Please list injury, birth defect, or congenital defect not mentioned above.

Maine residents:

You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the following questions.

Minnesota residents:

YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE: (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

Question 24: Please list any symptom, injury, birth defect, congenital defect, disease, or other disorder not mentioned above that has been diagnosed or treated by a medical practitioner.

North Carolina residents:

Question 21: Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Vermont residents:

Question 21: Has anyone been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

Wisconsin residents:

Question 6: Had any lab tests, x-ray, electrocardiogram, or other diagnostic testing other than HIV testing or those requested as part of routine physical with normal findings?

Disclosure Notice

I authorize Hartford to release information in its file to the Medical Information Bureau, Inc., and other insurance companies to whom I or my children may apply for Life or Health Insurance, or other persons or organization, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, sold, or transferred to any person without first obtaining my consent or a written form stating the use and need for such information.

I understand that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself or my children in connection with this application.

I understand that if I request details about any medical record information collected about myself in connection with this application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I understand that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage.

Summary of information: In order to properly underwrite your request for group benefits, Hartford must collect certain information about your physical condition. You are the most important source of information about your own health, and to the degree it is possible, We will rely on only information obtained from you. If We do find We are required to contact a medical professional or institution, We may contact them directly using the authorization on the application form.

Information We collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people that have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

In most cases the only information We will collect is provided by you. You are encouraged to keep a copy of this form for your records. If We find it necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which We have collected. Upon written request, We will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to Us. Details regarding your right to correct or amend information in your file will be furnished upon written request. If you have any further questions about these policies and practices, please write to: Group Medical Underwriting, Hartford Life Insurance Companies, PO Box 2999, Hartford, CT 06104-2999.